Complete Summary

GUIDELINE TITLE

Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Sep. 62 p. (Public health guidance; no. 15). [25 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Cardiovascular disease
- Hyperlipidemia
- Hypertension
- Other smoking-related diseases

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Prevention
Risk Assessment

CLINICAL SPECIALTY

Cardiology
Family Practice
Internal Medicine
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Patients
Pharmacists
Physician Assistants
Physicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

To help National Health Service (NHS) organizations, local health and social care services as well as the community and voluntary sectors plan and deliver the most effective and most cost-effective services to reduce the rate of premature death from cardiovascular disease and other smoking-related diseases

TARGET POPULATION

Adults in England who are disadvantaged* and who smoke and/or are eligible for statins and/or who are at high risk of cardiovascular disease due to other factors.

*__Note__: Adults who are "disadvantaged" include, but are not limited to:

- Those on a low income (or who are members of a low-income family)
- Those on benefits
- Those living in public or social housing
- Some members of black and minority ethnic groups
- Those with a mental health problem
- Those with a learning disability
- Those who are institutionalised (including those serving a custodial sentence)
- Those who are homeless

INTERVENTIONS AND PRACTICES CONSIDERED

1. Identifying adults at risk for cardiovascular disease and/or other smoking-related diseases

2. Improving services for adults and access to services
3. Providing system incentives for local projects that improve the health of disadvantaged people
4. Developing and sustaining partnerships with healthcare professionals and community workers
5. Ensuring adequate training of service providers and practitioners

Note: These interventions and practices are considered within the context of providing smoking cessation and statin interventions as the basis of the recommendations.

MAJOR OUTCOMES CONSIDERED

- Rates of contact with disadvantaged adults and sources of contacts
- Rates of premature deaths from cardiovascular disease and other smoking-related diseases
- Rates of smoking cessation and use of smoking cessation medication
- Rates of lipid testing and use of statins
- Rates of blood pressure monitoring
- Rates of treatment compliance
- Identification of barriers to outreach
- Cost-effectiveness
- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): Key questions were established as part of the scope. They formed the starting point for the review of evidence and facilitated the development of recommendations by the Public Health Interventions Advisory Committee (PHIAC) (refer to appendix B in the original guideline document for a list of the key questions).

The two overarching questions focused on the use of statins to combat cardiovascular disease (CVD) and smoking cessation activities.

Evidence of Effectiveness

Two reviews of effectiveness were conducted.

Identifying the Evidence

The following databases were searched (from 1995 to 2007):

- AMED (Allied and Complementary Medicine)
- ASSIA (Applied Social Science Index and Abstracts)
- British Nursing Index

- CINAHL (Cumulative Index of Nursing and Allied Health Literature)
- Cochrane Central Register of Controlled Trails
- Cochrane Database of Systematic Reviews (CDSR)
- Database of Abstracts of Reviews of Effectiveness (DARE)
- EMBASE
- EPPI Centre Databases
- HMIC (Health Management Information Consortium – comprises King's Fund and DH-Data databases)
- MEDLINE
- PsychINFO
- SIGLE (System for Information on Grey Literature in Europe)
- Social Policy and Practice
- Sociological Abstracts

Other relevant databases (including sources of grey literature) were also searched, along with references from included studies. The following websites were searched:

- Community Development Exchange (CDX)
- Department of Health coronary heart disease policy section
- European directory of good practices to reduce health inequalities
- National Health Service (NHS) networks
- World Health Organization (WHO) Health Evidence Network

In addition, information was sought from experts.

Selection Criteria

Studies of primary and secondary prevention activities were included in the effectiveness reviews if they aimed to:

- Find and then support adults at increased risk of developing (or with established) coronary heart disease (CHD) (note, the statins search included CVD)
- Provide adults at increased risk of developing (or with established) CHD with support services – or improved access to those services (note, the statins search included CVD)
- Find and help people who smoke (aged 16 years and over) to stop or reduce the habit
- Provide people who smoke (aged 16 years and over) with smoking cessation services – or improve their access to those services.

Studies were excluded if the interventions:

- Did not aim to reduce or eliminate premature deaths from CHD or other smoking-related causes
- Tackled the wider determinants of health inequalities (for example, using macro-level policies to tackle poverty and economic disadvantage).

Economic Appraisal

The economic appraisal consisted of a review of economic evaluations, four cost-effectiveness reports, and a supplementary cost-effectiveness analysis.

Review of Economic Evaluations

The review was conducted using the databases listed for the effectiveness reviews and the following economic databases:

- Econlit
- Health Economic Evaluation Database (HEED)
- NHS Economic Evaluation Database (NHS EED)

The small number of studies involved and the difficulties involved in making direct comparisons across studies (for instance, due to lack of information on the base year used to estimate prices) meant that it was not possible to undertake a quantitative synthesis of the results.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Study Type

- Meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs (including cluster RCTs)
- Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies
- Non-analytical studies (for example, case reports, case series)
- Expert opinion, formal consensus

Study Quality

++ All or most criteria have been fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter.

+ Some criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.

- Few or no criteria have been fulfilled. The conclusions of the study are thought likely or very likely to alter.

METHODS USED TO ANALYZE THE EVIDENCE

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Evidence of Effectiveness

Quality Appraisal

Included papers were assessed for methodological rigour and quality using the National Institute for Health and Clinical Excellence (NICE) methodology checklist, as set out in the NICE technical manual 'Methods for development of NICE public health guidance' (see appendix E in the original guideline document). Each study was described by study type and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Summarising the Evidence and Making Evidence Statements

The review data was summarised in evidence tables (see full reviews [see the "Availability of Companion Documents" field]). The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Study of Current Practice

The mapping review aimed to identify and describe smoking cessation interventions and the provision of statins in disadvantaged areas and among disadvantaged individuals. See the original guideline document for more details.

Cost-Effectiveness Analysis

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The approach was applied to all four cost effectiveness reports. The results are reported in:

- 'Economic analysis of interventions to improve the use of statins interventions in the general population.'
- 'Economic analysis of interventions to improve the use of statins in disadvantaged populations.'
- 'Economic analysis of interventions to improve the use of smoking cessation interventions in the general population.'
- 'Economic analysis of interventions to improve the use of smoking cessation interventions in disadvantaged populations.'

An additional, supplementary economic analysis was undertaken to answer a number of questions posed by Public Health Interventions Advisory Committee (PHIAC).

The above reports are available on the NICE website at: http://www.nice.org.uk/PH15.

Fieldwork

Fieldwork was carried out to evaluate the relevance and usefulness of NICE guidance for practitioners and the feasibility of implementation. It was conducted with practitioners and commissioners who are involved in smoking cessation services and statin provision. Participants included: strategic health authority directors, primary care trust directors of public health and public health teams, commissioning managers and performance managers, general practitioners (GPs) and primary care nurses. They also included community pharmacists, health trainers and managers and representatives from other public and voluntary organisations, including New Deal for Communities.

The fieldwork comprised:

A qualitative study involving a range of different professionals across four locations (Coventry, Liverpool, London and Northampton) carried out by Dr Foster Intelligence. The main issues arising from this study are set out in appendix C under fieldwork findings. The full fieldwork report 'Reducing the rate of premature deaths from CVD and other smoking-related diseases: finding and supporting those most at risk and improving access to services' is available on the NICE website: http://www.nice.org.uk/PH15.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

How Public Health Interventions Advisory Committee (PHIAC) Formulated the Recommendations

At its meetings in November 2007 and March 2008 PHIAC considered the evidence of effectiveness and cost effectiveness to determine:

- Whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- Whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal
- Where there is an effect, the typical size of effect

PHIAC developed draft recommendations through informal consensus, based on the following criteria.

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope
- Effect size and potential impact on population health and/or reducing inequalities in health
- Cost effectiveness (for the National Health Service [NHS] and other public sector organisations)
- Balance of risks and benefits

- Ease of implementation and the anticipated extent of change in practice that would be required

Where possible, recommendations were linked to an evidence statement(s) (see appendix C of the original guideline document for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Smoking cessation interventions are generally cost effective, irrespective of the target audience, the methods used to identify and recruit adults or the type of service offered. It is also cost effective to identify adults in secondary care who are disadvantaged and need statins (and then prescribe these drugs). In primary care, the cost effectiveness of identifying people at risk of cardiovascular disease (CVD) and providing them with statins is determined by the number at risk of CVD in the baseline population. (The more people at risk, the more cost effective it becomes to identify them and provide them with statins.)

Smoking Cessation

The cost per quality-adjusted life year (QALY) of smoking cessation interventions for disadvantaged groups is low or very low. It is rarely likely to exceed 6,000 pounds.

Statins

Secondary prevention of CVD (that is, after a CVD event) among a disadvantaged population costs an estimated 4,000 pounds per QALY gained (3,100 pounds per QALY for finding the person and 900 pounds per QALY for treating them with statins). Therefore, it is cost effective.

Whether or not it is cost effective to provide statins to prevent a first occurrence of CVD among a disadvantaged population depends on the number of people at risk in the baseline population. Data from a USA study of financially disadvantaged women aged 40 to 64 who enrolled in the National Breast and Cervical Cancer Early Detection Program was analysed. The analysis found that it is cost effective if more than 14% of the population is at risk. For example, when 40% were at risk of CVD, primary prevention was estimated to cost 8,500 pounds per QALY gained (4,900 pounds per QALY for finding the person and 3,600 pounds per QALY for treating them). This compared with about 125,600 pounds when only 1.6% were at risk (122,000 pounds per QALY for finding them and 3,600 pounds per QALY for treating them).

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The draft guidance, including the recommendations, was released for consultation in April 2008. At its meeting in June 2008, Public Health Interventions Advisory Committee (PHIAC) considered comments from stakeholders and the results from fieldwork and amended the guidance. The guidance was signed off by the National Institute for Health and Clinical Excellence (NICE) Guidance Executive in July 2008.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The definitions of adults who are disadvantaged may be found at the end of the "Major Recommendations" field.

Recommendation 1: Identifying Adults at Risk

Who Is the Target Population?

Adults who are disadvantaged:

- Who smoke and/or
- Who are eligible for statins and/or
- Who are at high risk of cardiovascular disease (CVD) due to other factors

Who Should Take Action?

Service providers and commissioners (for example, general practices, primary care trusts (PCTs), community services, local authorities and others with a remit for tackling health inequalities).

What Action Should They Take?

- Primary care professionals should use a range of methods to identify adults who are disadvantaged and at high risk of premature death from CVD. These include:
    - Primary care and general practice registers (for example, to identify adults who smoke; who are from particular minority ethnic groups; or who have family members who have had premature coronary heart disease)
    - Primary care appointments (for example, during routine visits and screening)
    - Systematic searches in pre-identified areas or with specific populations (for example, using direct mail or telephone)
    - Analyses of quality outcomes framework (QOF) data

- Those working with communities should use a range of methods to identify adults who are disadvantaged and at high risk of CVD. Methods to use include:
    - Health sessions run at a range of community and public sites, including post offices, charity shops, supermarkets, community pharmacies, homeless centres, workplaces, prisons and long-stay psychiatric institutions. (Lifestyle factors such as smoking or other indicators, such as blood pressure, could be used to identify those at risk)
    - Culturally sensitive education sessions that include a CVD risk assessment and which take place in black and minority ethnic community settings (including places of worship)
    - Outreach activities provided by community health workers (including health trainers)
- Service providers should monitor these methods and adjust them according to local needs.
- Service providers should encourage everyone who is disadvantaged to register with a general practice.

Recommendation 2: Improving Services for Adults and Retaining Them

Who Is the Target Population?

Adults who are disadvantaged:

- Who smoke and/or
- Who are eligible for statins and/or
- Who are at high risk of CVD due to other factors

Who Should Take Action?

Service providers (for example, PCTs, general practices, community services, local authorities and other organisations with a remit for tackling health inequalities).

What Action Should They Take?

- Provide flexible, coordinated services that meet the needs of individuals who are disadvantaged. For example, this could include providing drop-in or community-based services, outreach and out-of-hours services, advice and help in the workplace and single-sex sessions.
- Involve people who are disadvantaged in the planning and development of services. Seek feedback from the target groups on whether the services are accessible, appropriate and meeting their needs.
- Gain the trust of adults who are disadvantaged. Offer them proactive support. This could include helplines, brochures and invitations to attend services. It could also include providing general practitioners (GPs) with postal prompts to remind them to monitor people who are disadvantaged and who have had an acute coronary event.
- Develop and deliver non-judgemental programmes to tackle social and psychological barriers to change. These should be tailored to people's needs. For example, they could make use of social marketing techniques. (Social marketing involves using marketing and related techniques to achieve specific behavioural goals.)

- Ensure services are sensitive to culture, gender and age. For example, provide multi-lingual literature in a culturally acceptable style and involve community, religious and lay groups in its production. Where appropriate, offer translation and interpretation facilities. Promote services using culturally relevant local and national media, as well as representatives of different ethnic groups. Consider providing information in video or web-based format.
- Provide services in places that are easily accessible to people who are disadvantaged (such as community pharmacies and shopping centres) and at times to suit them.
- Provide support to ensure people who are disadvantaged can attend appointments (for example, this may include help with transport, postal prompts and offering home visits).
- Encourage and support people who are disadvantaged to follow the treatment that they have agreed to. For example, encourage them to use self-management techniques (based on an individual assessment) to solve problems and set goals. It could also involve providing vouchers for treatments (such as nicotine replacement therapy [NRT]). (For recommendations on the principles of behaviour change, see 'Behaviour change at population, community and individual levels' [NICE public health guidance 6].)
- Routinely search GP databases (and other electronic medical records) to generate lists of patients who have not collected repeat prescriptions or attended follow-up appointments. Make contact with them.
- Address factors that prevent people who are disadvantaged from using services (for example, they may have a fear of failure or of being judged, or they might not know what services and treatments are available).
- Support the development and implementation of regional and national strategies to tackle health inequalities by delivering local activities which are proven to be effective.
- Use health equity audits to determine if services are reaching people who are disadvantaged and whether they are effective*. (For example, by matching the postcodes of service users to deprivation indicators and smoking prevalence.)

*Health equity audits typically consist of six steps: 1) Agreeing partners and issues for the audit 2) Undertaking an equity profile 3) Identifying high-impact local action to narrow key inequities identified 4) Agreeing priorities for action 5) Securing changes in investment and service delivery 6) Reviewing progress and assessing impact. DH (2004) Health equity audit: a self-assessment tool. London: DH.

Recommendation 3: System Incentives

Who Is the Target Population?

Service providers (for example, PCTs, community services, local authorities and others with a remit for tackling health inequalities) and practice-based commissioning (PBC) groups.

Who Should Take Action?

Policy makers, planners and commissioners.

What Action Should They Take?

- Support and sustain activities aimed at improving the health of people who are disadvantaged by:
    - Using relevant indicators to measure progress and compare performance across areas or organisations
    - Ensuring, wherever possible, that all targets aim to tackle health inequalities – and do not increase them
    - Ensuring exception-reporting does not increase health inequalities: PCTs should be provided with additional levers and tools to monitor and benchmark exception-reporting and to reduce persistent rates of exception coding
    - Considering the provision of comparative performance data to encourage providers to meet targets
    - Using local enhanced services to encourage providers and practitioners to identify and continue to support those who are at risk of premature death from CVD and other smoking-related diseases
- Provide incentives for local projects that improve the health of people who are disadvantaged, specifically those who smoke or are at high risk of CVD from other causes or are eligible for statins. Ensure the projects are evaluated and, if effective, ensure they continue.

Recommendation 4: Partnership Working

Who Is the Target Population?

Adults who are disadvantaged:

- Who smoke and/or
- Who are eligible for statins and/or
- Who are at high risk of CVD due to other factors

Who Should Take Action?

Planners, commissioners and service providers with a remit for tackling health inequalities. This includes PCTs, general practices, community services, PBC groups, local strategic partnerships, local authorities (including education and social services), the criminal justice system and members of the voluntary and business sectors.

What Action Should They Take?

- Develop and sustain partnerships with professionals and community workers who are in contact with people who are disadvantaged. Use joint strategic needs assessments, local area agreements, local strategic partnerships, the GP contract, world class commissioning and other mechanisms. (For recommendations on community engagement see 'Community engagement to improve health' [NICE public health guidance 9]).
- Establish relationships between primary care practitioners and the community to understand how best to identify and help adults who are disadvantaged to adopt healthier lifestyles. For example, they should jointly determine how best to support health initiatives delivered as part of a local neighbourhood renewal strategy.

- Establish relationships with secondary care professionals (for example, those working in respiratory medicine and CVD clinics) to help identify patients at high risk of further cardiovascular events. Offer these patients support or refer them on, where appropriate.
- Develop and maintain a database of local initiatives that aim to reduce health inequalities by improving the health of people who are disadvantaged.
- Develop and sustain local and national networks for sharing local experiences. Ensure mechanisms are in place to evaluate and learn from these activities on a continuing, systematic basis.
- Ensure those working in the healthcare, community, and voluntary sectors coordinate their efforts to identify people who need help.

Recommendation 5: Training and Capacity

Who Is the Target Population?

Service providers (for example, general practices, PCTs, local authorities, community and lay workers and others with a remit for tackling health inequalities).

Who Should Take Action?

Commissioners and service providers (for example, PCTs, community services, local authorities and others with a remit for tackling health inequalities).

What Action Should They Take?

- Ensure there are enough practitioners with the necessary skills to help people who are disadvantaged to adopt healthier lifestyles. (For examples of the skills needed, see National Guideline Clearinghouse (NGC) summaries of National Institute for Health and Clinical Excellence (NICE) public health guidance 1.: Brief interventions and referral for smoking cessation in primary care and other settings; Workplace health promotion: how to help employees to stop smoking [NICE public health guidance 5]; Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities [NICE public health guidance 10]; and the NICE Standard for training in smoking cessation treatments or updated versions of this.
- Ensure practitioners have the skills to identify people who are disadvantaged and can develop services to meet their needs. (For a set of generic principles to use when planning and delivering activities aimed at changing health-related behaviour see: 'Behaviour change at population, community and individual levels' [NICE public health guidance 6]. For advice on getting communities involved see 'Community engagement to improve health' [NICE public health guidance 9].)
- Ensure service providers and practitioners have the ability to make services responsive to the needs of people who are disadvantaged. For example, they should be able to compare service provision with need, access, use and outcome using health equity audits. (For examples of the training and skills needed, refer to national organisations such as the Faculty of Public Health, British Psychological Society, Skills for Health and the Institute of Environmental Health.)

Definition

Adults who are disadvantaged include (but are not limited to):

- Those on a low income (or who are members of a low-income family)
- Those on benefits
- Those living in public or social housing
- Some members of black and minority ethnic groups
- Those with a mental health problem
- Those with a learning disability
- Those who are institutionalised (including those serving a custodial sentence)
- Those who are homeless

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type and quality of supporting evidence is identified and graded for each recommendation (see Appendix C of the original guideline document).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved identification and support of those most at risk of early death
- Improved access to services
- Reduced rates of premature death from cardiovascular and other smoking-related diseases

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This guidance represents the views of the National Institute for Health and Clinical Excellence (NICE) and was arrived at after careful consideration of the evidence available. Those working in the National Health Service (NHS), local authorities, the wider public and the voluntary and community sectors should take it into account when carrying out their professional, managerial or voluntary duties.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their

responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.
- This guidance should be used alongside NICE guidance on smoking cessation, lipids and statins.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

National Institute of Health and Clinical Excellence (NICE) guidance can help:

- National Health Service (NHS) organisations meet the Department of Health (DH) standards for public health as set out in the seventh domain of 'Standards for better health' (updated in 2006). Performance against these standards is assessed by the Healthcare Commission, and forms part of the annual health check score awarded to local healthcare organisations.
- NHS organisations, social care and children's services meet the requirements of the DH's 'Operating framework for 2008/09' and 'Operational plans 2008/09–2010/11'.
- NHS organisations, social care and children's services meet the requirements of the Department of Communities and Local Government's 'The new performance framework for local authorities and local authority partnerships'.
- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Local authorities fulfil their remit to promote the economic, social and environmental wellbeing of communities.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for children's trusts, health and wellbeing partnerships and other multi-sector partnerships working on health within a local strategic partnership.
- NICE has developed tools to help organisations implement this guidance. These are available on the NICE website at http://www.nice.org.uk/PH15 (see also the "Availability of Companion Documents" field).

Tackling Health Inequalities

- Health inequalities are so deeply entrenched that providing disadvantaged groups or areas with better services – and better access to those services – can only be one element of a broader strategy to address the distribution of the wider determinants of health. All activities need to be developed and sustained on a long-term basis.
- The recommendations focus on system and structural changes to ensure effective clinical and public health practice can take place. This requires a comprehensive approach at all levels of the health system (for example, involving both practitioners and commissioners) and in partnership with others in the wider public, community and voluntary sectors. The

recommendations are not aimed at clinical practice itself as the relevant advice is found in other NICE guidance.
- Effective implementation of the recommendations will require:
    - An appropriate infrastructure and resources for commissioners, planners and service providers
    - Policy initiatives which prioritise health inequalities and ensure action to tackle them are included in primary care trust plans and local area agreements.

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides
Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Sep. 62 p. (Public health guidance; no. 15). [25 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Sep

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

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NICE Project Team
Public Health Interventions Advisory Committee (PHIAC)

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Public Health Interventions Advisory Committee are required to make an oral declaration all potential conflicts of interest at the start of the consideration of each public health intervention appraisal. These declarations will be minuted and published on the National Institute for Health and Clinical Excellence (NICE) website.

Members are required to provide in writing an annual statement of current conflicts of interests, in accordance with the Institute's policy and procedures.

Potential members of the Public Health Programme Development Groups (PDG), and any individuals having direct input into the guidance (including expert peer reviewers), are required to provide a formal written declaration of personal interests. A standard form has been developed for this purpose which also includes the Institute's standard policy for declaring interests. This declaration of interest form should be completed before any decision about the involvement of an individual is taken.

Any changes to a Group member's declared conflicts of interests should also be recorded at the start of each PDG meeting. The PDG Chair should determine whether these interests are significant. If a member of the PDG has a possible conflict of interest with only a limited part of the guidance development or recommendations, that member may continue to be involved in the overall process but should withdraw from involvement in the area of possible conflict. This action should be documented and be open to external review. If it is considered that an interest is significant in that it could impair the individual's objectivity throughout the development of public health guidance, he or she should not be invited to join the group.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Identifying and supporting people most at risk of dying prematurely. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Sep. 8 p. (Public Health Intervention Guidance 15). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Costing statement: identifying and supporting people most at risk of dying prematurely. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Sep. 7 p. (Public Health Intervention Guidance 15). Available in Portable Document Format (PDF) from the NICE Web site.
- Identifying and supporting people most at risk of dying prematurely. Slide set. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. 16 p. (Public Health Intervention Guidance 15). Available in Portable Document Format (PDF) from the NICE Web site.
- Identifying and supporting people most at risk of dying prematurely. Consultation documents. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008. (Public Health Intervention Guidance 15). Available in Portable Document Format (PDF) from the NICE Web site.
- The public health guidance development process. An overview for stakeholders including public health practitioners, policy makers and the public. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Mar. 46 p. Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1683. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

None available

NGC STATUS

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